AUTHORIZATION FOR RELEASE OF INFORMATION

Submit this completed form to authorize KISS ABA provide to information to an outside entity. Please use a separate form for each provider.

I/We hereby give permission and consent to KISS ABA to release confidential information (e.g., behavioral assessments/data, etc.) in the clinical record of my child/ward to the following:

Name: _____ Title: _____

Company/School/Practice: _____

Street Address:_____

City: _____ State: _____ Zip: _____

Phone: (_____) _____-_____ Email: _____

Name of KISS ABA Client:_____ Date of Birth: _____/ _____ / _____

_____

Parent/Guardian #1 Name (Printed)

_____ _____ / _____ / _____

Parent/Guardian #1 (Signature) Date

_____

Parent/Guardian #2 Name (Printed)

_____ _____ / _____ / _____

Parent/Guardian #2 (Signature) Date